Comments to the Medicaid Revitalization Committee
August 2, 2006
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Thank you for the opportunity to present these comments. I am Dr. Brian Meyer, the Executive Director of the Virginia Treatment Center for Children at the VCU Medical Center. I am also the Chair of the Child and Family Behavioral Health Policy and Planning Committee, a legislatively-mandated workgroup that provides an annual report to the Governor and the Legislature regarding the state of children's behavioral health services in the Commonwealth. The Committee's reports include recommendations for changes to state law, policy, and the annual budget. The recommendations I make today come from the Committee's just-released 2006 report.

Children's behavioral health services in Virginia are in crisis. In every area of the state, urban and rural, we hear complaints that mental health and substance abuse services for children are either unavailable or that the waiting lists are so long – four months for an outpatient visit, six months to see a child psychiatrist – that families cannot obtain services when they need them. The lack of treatment capacity is caused by inadequate funding for these services. We also have a serious imbalance in the system which is represented in Medicaid in which low end services like outpatient therapy and medication management, and high end services like acute inpatient care and residential treatment, are funded, but the intermediate services that children and adolescents need to prevent placement are neither funded nor available. Thus the Commonwealth spends hundreds of millions of dollars annually on restrictive high end services that remove children from their families and communities.

In making the following recommendations, we keep in mind three facts. First, treating behavioral health problems when children are young decreases later costs of behavioral health services. Second, treating behavioral health problems lowers the cost of treating other health care problems. Third, treating behavioral health problems lowers later costs to larger systems that are also funded by the state, including education and juvenile and criminal justice, such that every $1 spent saves $4 later.

Our Committee makes the following recommendations regarding Medicaid:

1. DMAS should conduct a study of intermediate level behavioral health services for children to determine which services, if funded by Medicaid, would significantly reduce utilization of restrictive residential placements in favor of home- and community-based services. In particular, we recommend studying such services as crisis intervention programs, mobile crisis teams, in-home family therapy and intensive in-home family therapy, respite care, wraparound services, intensive case management, afterschool behavioral health programs, intensive outpatient programs, and services for youth with co-occurring mental health and substance abuse problems. We believe it is far better to spend the funds keeping children with their families in the least restrictive possible environment.

2. DMAS should fund adolescent substance abuse services and services for youth with co-occurring mental health and substance abuse problems. We know that the adult outcomes of poor health, lowered productivity, DUI fatalities, and broken families, to name a few, could be significantly decreased if teens with substance abuse problems were treated. Half of all youth with mental health problems have co-occurring substance abuse problems, yet Medicaid pays only for mental health services, which does not address half of the problem. A study conducted several years ago by DMAS concluded that providing adolescent substance abuse treatment services would cost only $5.5 million per year.

3. We recommend that DMAS study suspending rather than ending Medicaid benefits when youth are incarcerated. Many youth are required to obtain appointments for mental health services before they can be released, but they cannot because their benefits have been ended.

4. EPSDT continues to be underutilized throughout Virginia. We recommend that DMAS provide regional trainings to pediatricians, family practitioners, case managers, DSS social workers, and service providers to expand the use of EPSDT screenings.

5. Any reshaping of Medicaid funding must address the real cost of providing services. Behavioral health service reimbursement rates have not been studied by DMAS since 1994. Our committee has found that the major reason there is a shortage of acute psychiatric inpatient beds for children, and that hospitals continue to close beds, is inadequate reimbursement rates. In particular, we recommend that Medicaid rates for outpatient psychiatric appointments, acute inpatient hospitalizations, day treatment, intensive in-home services, and behavioral health care provided by primary care physicians be studied.

We believe that taking these five simple steps would go a long way toward increasing the mental health of today's youth and tomorrow's adults. Thank you.